Health Disparities

with a

Focus on the Homeless Population

2006 Summit on the Burden of Cancer in Tennessee

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A signpost

Disparities "acts like a signpost…indicating that something is wrong".

Overview of today's discussion

Health disparities

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The homeless population in the U.S.

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Health disparities among the homeless population

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Efforts to reduce health disparities among the homeless population in Knoxville

Health disparities

Troubling statistics: An overview

- African Americans & Hispanics are overrepresented among the 45 million uninsured Americans
- Infant mortality rates for black infants are nearly two-and-a-half times greater than the rate for white infants.
- Rate of diabetes is 30% higher in Native Americans than in Hispanics and whites.
- Mortality rates for cancer, diabetes & stroke are significantly higher in African Americans than whites.
- Highest prevalence of childhood obesity is seen in Mexican American males & African American females
- People of color are underrepresented in dentistry, medicine, nursing & public health.

- Racial & ethnic disparities have been noted in:
  - Mortality
  - Disability
  - Morbidity
  - Health status

- Others have noted differences due to other factors, including:
  - Geography
  - Age
  - Gender
  - Disability status
  - Sexual orientation

A wake-up call

- In the past decade, there has been a focus on evidence about differences in health status & health care among various population cohorts.
- Many credit the release of the IOM's , report, *Unequal Treatment,* as the watershed event that made understanding & eliminating disparities a national priority.
- Evidence about disparities though has strong historical roots.

A national call to action

Healthy People 2010 committed the nation to the over-arching goal to "eliminate health disparities".

What is a disparity?

disparity [di spar ə tē]

n.

pl. disparities Fr *disparité* < ML *disparitas* < L *dispar*, unequal: see DIS- & PAR1

1. inequality or difference, as in rank, amount, quality, etc.

2. unlikeness; incongruity

Disparities in health status & health care

- Why highlight a difference between health *status* & health *care*?
- What is the difference?
- How does an understanding of the difference inform practice?

Health determinants & factors (Health Canada)

- Income & social status
- Social support networks
- Education
- Employment & working conditions
- Social environments
- Physical environments
- Personal health practices & coping skills
- Healthy child development
- Biological & genetic endowment
- **Health services**
- Gender
- Culture
- Other: health promotion, environmental sustainability, globalization & the role of the media in health promotion

Building an understanding

- The common denominator of various definitions of health disparities is *differences…*population differences in:
  - Environmental exposures
  - Health care access, utilization or quality
  - Health status
  - Health outcomes
  - Other

What's in a name?

- Health disparities have come to mean many different things:
  - Some definitions are relatively narrow: IOM & DHHS initiatives have focused primarily on racial & ethnic disparities; Healthy People 2010 focus is much broader
  - Sometimes disparity is used interchangeably with racial & ethnic differences in health.
  - Some use the terms disparity, inequality & inequity interchangeably.

A broad definition

The National Institutes of Health defines health disparities as “the differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States”.

Social justice

- The concept of health disparity has also taken on the implication of *injustice.*
  - The rationale is that if a difference, *or inequality,* is *avoidable* and *unfair,* it is an inequity.
- Whitehead (1991) defines a health disparity as: “differences in health which are not only unnecessary and avoidable, but, in addition, are considered unfair and unjust”

Determinants of health disparities: Whitehead

- Natural, biological variation
- Freely chosen health-damaging behavior, such as participation in certain sports or pastimes
- Transient health advantage of one group over another when one group adopts a health-promoting behavior first
- Health-damaging behavior in which the degree of choice of lifestyles is severely restricted
- Exposure to unhealthy, stressful living & working conditions
- Inadequate access to essential services
- Natural selection, or health-related social mobility involving the tendency for sick people to move down the social scale

A multitude of factors

- Health disparities are a result of a multitude of factors, including:
  - Racism & other discrimination
  - Psychosocial
  - Cultural
  - Socioeconomic
  - Environmental
  - Quality of care
  - Policy factors

Solutions must be multi-factorial

- Selected recommendations for health care delivery:
  - Understand & target population-specific differences in risk factors
  - Develop prevention messages with a specific clinical focus
  - Promote self-care & the use of health-promoting services
  - Increase utilization of needed services
  - Enhance access

Recommendations *cont'd.*

- Selected other recommendations:
  - Diversify the workforce
  - Increase data collection & analysis to enhance evidence-based practice
  - Increase cross-cultural & other training of the health care workforce
  - Avoid fragmentation of health plans along socioeconomic lines
  - Strengthen the patient-provider relationship in publicly funded plans.

The homeless population in the U.S.

Homelessness

- What does it mean to be homeless?

Homelessness

- More than 760,000 persons sleep on the streets

  or in shelters every night.
- In the late 1990's, 2.3-3.5 million people were homeless at some time during an average year.
- Approximately 12 million adults in the U.S. have experienced homelessness during their lifetime.

Housing

- Requests for assisted housing increased 86%.
- Average wait: 16 months for public housing; 20 months for Sec. 8 Certificates; 22 months for Sec. 8 Vouchers.
- 19% of cities have stopped accepting applications for at least one assisted housing program due to excessive length of waiting lists.

Cost of housing

- The federal minimum wage has remained at $5.15 since 1997
- The national median housing wage is $13.75 an hour
- There is no locale in the U.S. where housing is affordable at the minimum wage

Commonalities and differences

Although homeless persons have common needs for housing, income and employment, the population is also very diverse.

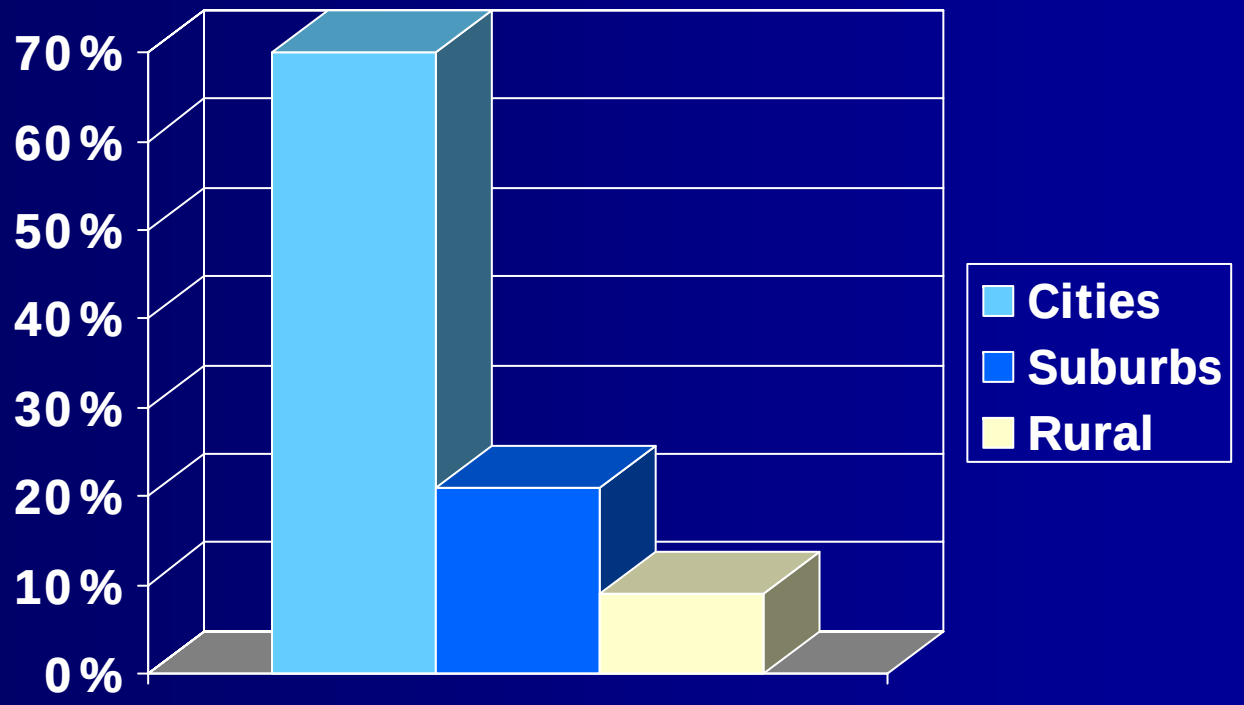
What are the advantages to evaluating differences among the homeless groups?

- Each group has unique service needs; identifying these needs is critical for program planning and design.
- Understanding differences can guide agencies in hiring staff with skills that are matched to their client's needs
- A focus on differences can provide crucial information to guide development of responsive inter-organizational service networks.

What are the disadvantages to evaluating differences among the homeless groups?

- Distracts attention from common needs for housing, income, employment
- Results in a focus on personal failing
- Reinforces concept of different levels of deservingness

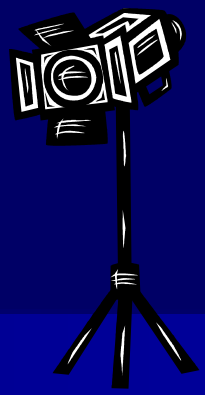
Where do people that are homeless live?



Who becomes homeless?

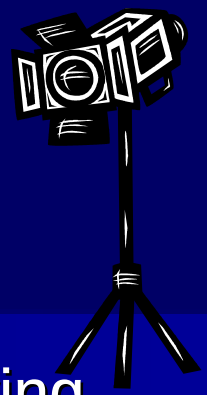
- Predominantly male (68%) and non-white (53%)
- 66% are single adults and 34% are families
- 60% of homeless women and 41% of homeless men have minor children (0-17 years of age)
  - 28% of these children live with their homeless parent(s)
- 84% of homeless families are headed by women
- Almost 80% are between the ages 20 – 64

Spotlight: Gender issues



- Many more women have become homeless with the ratio of men to women approaching 3:2; includes:
  - Homeless mothers (i.e., families with children in tow)
  - Homeless women alone (“singles”)

Spotlight: Homeless families



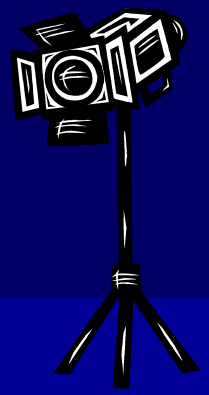
- Homeless families represent the fastest growing segment of the homeless population and now comprise approximately 36 percent of the overall numbers.

Age distribution of the homeless

AGE	#	%
0-12	59,352	12.0
13-19	30,747	6.2
20-44	282,680	57.0
45-64	111,222	22.5
65-84	10,773	2.2
85+	621	0.1
Total	495,396	100%

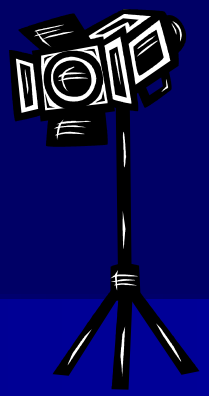
- While not the majority, the following age groups are increasing and are vulnerable because of their frailty and dependence on others
  - Children
  - Youth/adolescents
  - Elderly

Spotlight: Street youth



- 730,000 to 1.3 million nationally
- 25% permanently homeless
- 50% runaway secondary to abuse
- 75% engaged in illegal activity
- 50% involved with prostitution
- 50% alcoholic, 80% street drugs, 35% IV drug use

Spotlight: Elderly adults

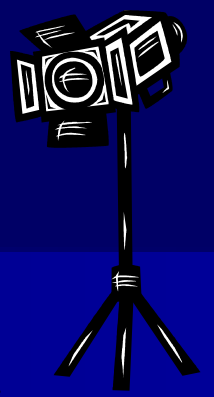


- The number of homeless elderly adults is likely to escalate as homelessness continues unabated, increasing numbers of Baby Boomers reach older adulthood, and the demand for affordable housing continues to outstrip supply

Race/ethnicity of the homeless

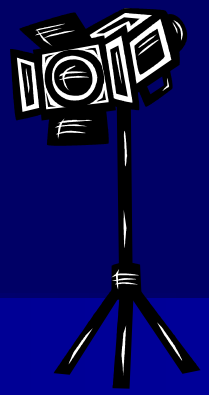
	% of Homeless	% of U.S. Adult
African American	40	11
Caucasian	41	76
Latino/ Hispanic	11	9
Native American	8	1
Other	1	3

Spotlight: African Americans



- Poor blacks living in urban settings were twice as likely to be homeless as poor whites in the same cities
  - Wealth is likely to be more important than income in the etiology of homelessness
  - White flight and the departure of middle class blacks to the suburbs have left pockets of concentrated poverty and reduced job opportunities in urban areas.
  - Extreme segregation of housing by race and class seriously augments the adverse effects of other types of economic disadvantage.

Spotlight: Latinos



- The under-representation of Latinos among homeless people in spite of their high poverty levels
  - Survey methods may systematically undercount Latinos in homeless samples
  - Latinos may have lower levels of personal risk factors such as psychiatric or substance abuse disorders that reduce their risk of homelessness
  - Latinos may face fewer social disadvantages than other groups, particularly compared to blacks
  - Exceptionally strong traditions of mutual familial support may be protective

Homeless children

- History of foster care , group home or other institutional setting - 27%
- History of childhood physical or sexual abuse - 25%
- History of childhood homelessness - 21%
- Ran away from home - 33%
- Forced to leave home - 22%

Health of homeless children

- Depression: Mean for homeless children=10.3 versus 8.3 for housed children (Children's Depression Inventory)
- Anxiety: 31% for homeless children versus 9% for housed children (need for further evaluation on Children's Manifest Anxiety Scale)
- Developmental delays: 54% homeless children; 16% housed children
- Higher rates of both acute and chronic health problems

Health of homeless adults

- Health conditions requiring regular, uninterrupted treatment, e.g.tuberculosis, HIV, addiction, and mental illness, are extremely difficult to manage without a stable residence.
- The *Institute of Medicine* has determined that individuals without a regular place to stay are far more likely than are those with stable housing to suffer from chronic medical conditions such as diabetes, cardiovascular disease, and asthma.

Obstacles to accessing care

- Lack of financial resources or health insurance
- Lack of awareness of services
- Fragmented service system
- Fear or distrust of large institutions
- Finding shelter and food are higher priorities than health care
- Lack of transportation

Obstacles to utilizing health care

- Lack of comprehensive services
- Language and cultural barriers
- Provider attitudes
- Scheduling difficulties
- Lack of documentation

Needs: Resources and policies

- Increase public awareness and understanding of homelessness.
- Recruit volunteer specialists from community.
- Have an interdisciplinary approach
- Solicit donations to help meet care needs.

Needs: Self-management support

- Focus on self-management goals identified by client
- Recognize patient priorities are meeting basic needs of food and shelter

Needs: Interdisciplinary teams and cross-training

- Create interdisciplinary team of medical, chemical dependency, social service, and mental health providers
- Cross train behavioral health and primary care providers

Designing effective delivery systems

- Identify clients that are homeless
- Gather contact data from patient at each encounter
- Provide walk in services and same day appointments
- Attempt to provide all services during a single visit
- Conduct outreach to streets, shelters, soup kitchens
- Use case managers to link patients to entitlements and benefits
- Conduct health education groups

Focus on the homeless population in Knoxville

Ten Year Plan to End Homelessness

- A joint project of Knoxville and Knox County
- Part of a national movement to end long-term or chronic homelessness
- Goals:
  - Review the extent of chronic homelessness and existing services in Knoxville and Knox County.
  - Solicit input that represents stakeholders and the larger community,
  - Define the problems that need to be addressed to reduce and prevent chronic homelessness,
  - Review “best practices” in other communities,

- Identify current and needed efforts, strategies, and models that will effectively address homelessness in Knoxville and Knox County,
- Develop a ten-year plan to end chronic homelessness with action steps and timelines.

Strategies

- Move people into housing first
- Stop discharging people into the streets (mental health hospitals; foster care)
- Increase coordination and effectiveness of services
- Increase economic opportunities
- Implement new data collection methods
- Develop permanent solutions
- Strengthen relationships with faith-based organizations
- Recognize homelessness as a community challenge
- Prevent homelessness

Knoxville Project Homeless Connect

- The goals of **Project Homeless Connect** are three-fold:
  - Improve access to services
  - Engage and increase the involvement of the business, non-profit community, and individual volunteers to work together to provide access to services
  - Leverage private, corporate and foundation money and in-kind support to augment city efforts to increase housing options and build service capacity for homeless Knoxvillians.

Project Connect is a part of the Ten Year Plan to End Homelessness

Knoxville Project Connect

- A one-day event focused on providing needed services to Knoxville's homeless population
  - Medical care
  - Dental and vision care services
  - Substance abuse and mental health counseling
  - Information and referral for housing
  - Legal assistance
  - A variety of social services which could help the homeless find pathways to housing and self sufficiency.

Numerous government offices, non-profit agencies and many, many committed volunteers participated .

Project Access

- A not-for-profit community health partnership that coordinates all medical care for the needy through a network of physician volunteers.

The People's Clinic
Volunteer Ministries-Knoxville

- The People's Clinic provides acute care medical, mental health and dental services to the homeless and indigent. Goals of the program are:
  - Support stabilization by providing temporary medication and to encourage and assist clients in obtaining long term care.
  - Restore the client to the best quality of life within his/her potential to function in the least financially and emotionally restrictive environment.

- Reduce symptoms by encouraging medication compliance as well as compliance with treatment plan.
- Provide referral for chronic conditions while temporarily treating those conditions which are of an acute nature

UT College of Nursing

- Faculty and students of the College of Nursing provide primary care services to the homeless population of Knoxville